IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
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BUREAU OF FACILITY STANDARDS
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September 23, 2009

Tom Whittemore
Communicare, Inc #9 Main
40 West Franklin Road, Suite F
Meridian, ID 83642

RE: Communicare, Inc #9 Main, provider #13G059

Dear Mr. Whittemore:

This is to advise you of the findings of the Medicaid/Licensure survey of Communicare, Inc #9 Main, which was conducted on September 17, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **October 6, 2009,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by October 6, 2009. If a request for informal dispute resolution is received after October 6, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

Michael A Case, LSW

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G059	A. BUILDING _____ B. WING _____	09/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNICARE, INC #9 MAIN	876 EAST MAIN JEROME, ID 83338

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		

The following deficiencies were cited during the annual recertification survey.

The survey was conducted by:
Michael Case, LSW, QMRP, Team Lead
Jim Troutfetter, QMRP

Common abbreviations/symbols used in this report are:

AQMRP - Assistant Qualified Mental Retardation Professional
LPN - Licensed Practical Nurse
QMRP - Qualified Mental Retardation Professional

RECEIVED
OCT - 8 2009
FACILITY STANDARDS

W 369	483.460(k)(2) DRUG ADMINISTRATION	W 369	W369	10-15-2009

The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.

This STANDARD is not met as evidenced by:
Based on observation, record review, and staff interview it was determined the facility failed to ensure medications were administered without error for 1 of 8 individuals (Individual #6) observed to take medications. This resulted in the potential for an individual not to receive the full dose of medications. The findings include:

1. Individual #6's 6/09 Physician's Order Sheet and Progress Note stated she was a 25 year old female. She received Lexapro [an antidepressant drug] 10 mg, Singulair [a respiratory tract drug] 10 mg, and Loratadine [an antihistamine drug] 10 mg each day.

Corrective Actions: Specific instructions have been added to the Medication Sheet and to the Self-Administration of Medications (SAMs) program for Individual #6. Yogurt has been changed to applesauce per Doctor's order with instructions to mix crushed pills with applesauce in a 30cc medication cup and to be sure all applesauce and medication is given. The LPN for CCI #9 is in the process of inservicing Med Passers in this procedure.

Identifying Others Potentially Affected: No other individuals at this location require crushed medications.

System Changes: Any future order for medication administration which

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	10-6-2009

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 369	Continued From page 1 During an observation on 7/15/09 from 6:55 - 7:45 a.m., staff were noted to crush Individual #6's Lexapro, Singulair, and Loratadine pills. Staff then opened a 6 ounce container of yogurt, poured the crushed pills into the yogurt, and handed the container to Individual #6. Individual #6 consumed the yogurt and pill mixture. When she finished, staff took the yogurt container and moved as if to throw it away. The surveyor asked for the container and noted it contained no less than 1.5 tablespoons of yogurt with visible pill fragments. When asked during the observation, the staff assisting Individual #6 with her medication programs stated he should have checked the container to ensure Individual #6 consumed all of her medications. The staff then scraped the remaining yogurt and pill fragments onto a spoon and handed the spoon to Individual #6. Individual #6 consumed there remaining yogurt and pill fragments. When asked during an interview on 9/17/09 from 10:25 - 10:50 a.m., the LPN stated staff should have placed a small amount of yogurt in a bowl, poured the crushed medications into the bowl, and allowed Individual #6 to consume her medications from the bowl. The LPN stated staff would be able to see all the yogurt had been consumed if it was in a bowl rather than the yogurt container. The facility failed to ensure Individual #6's medications were administered without error.	W 369	involves crushing medications will follow the procedures described above of putting instructions on the medication sheet and SAMs and having both the food and delivery method specified clearly. The RN Supervisor has reinserviced the LPN on this expectation. Monitoring: The RN Supervisor will review medication delivery methods during her routinely scheduled reviews to ensure proper instruction has been given.	
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals	W 382	W382 Corrective Actions: During observation, the Med Passer thought	10-31-2009

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W 382	Continued From page 2 locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all drugs and biologicals were maintained under locked conditions for 9 of 9 individuals (Individuals #1 - #9) residing in the facility. This resulted in the potential for harm in the event individuals accessed and ingested a drug. The findings include: 1. An observation was conducted on 9/15/09 from 6:05 - 6:55 a.m. During that time, two medication storage cabinets were noted to be located in the bathroom with the tub on the west side of the facility. Cabinet A contained medications for Individuals #3, #6, #8, and #9. Cabinet B contained medications for Individuals #1, #2, #4, #5, and #7. Cabinet A was noted to be unlocked from 6:05 - 6:40 a.m. During that time, staff would enter the bathroom to assist individuals with medications from Cabinet B, and would then leave the bathroom. Cabinet A remained unlocked. When asked, two staff that were present and assisting with medications both stated the cabinet should have remained locked. When asked during an interview on 9/17/09 from 10:25 - 10:50 a.m., the LPN stated the cabinet should have been locked unless staff were assisting individuals with mediations. However, since Cabinet A contained medications for individuals residing on the other side of the	W 382	he had locked the cabinet but did not double check to make sure that the lock was engaged correctly. This is not a normal occurrence and the staff member has been counseled. Delivery of medications from the pharmacy has been evaluated and a policy revision made related to this issue which is attached. Identifying Others Potentially Affected: All individuals at this location are potentially affected. System Changes: Effective immediately, all medication delivered by courier for both CCI operated homes in Jerome will be delivered to CCI #8 which is located next to the office. The Med Passer will then take the crates to the office and lock them in a cabinet in the bathroom and they will remain there until the LPN processes them. Not securing medications properly is considered a Medication Incident. We have updated our Medication Incident Disciplinary Policy (see attached) to address corrective actions to take when employees do not follow established medication administration policy. The RN Supervisor will also be starting an agency wide system of periodic medication pass recertification and current med passer at this location, including management level staff, will be involved in this	

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W 382	Continued From page 3 facility, the cabinet should have been locked during the time observed. 2. An observation was conducted on 9/15/09 from 6:05 - 6:55 a.m. During that time, there were two grey plastic storage containers sitting on top of the medication cabinets. These storage containers were held closed with plastic zip-ties. When asked, the staff present and passing medications stated the containers were filled with medications delivered from the pharmacy. The staff stated all medications were delivered in the same manner, and the storage containers remained on top of the medication cabinets until the nurse came and checked in the medications. When asked during an interview on 9/17/09 from 10:25 - 10:50 a.m., the QMRP stated pharmacy services had changed and they were still working out specifics with the new delivery system. The facility failed to ensure medications were locked except when being prepared for administration.	W 382	training 10/09. This recertification will review medication storage expectations. Monitoring: Not properly securing and/or storing medications are considered medication incidents according to CCI policy. All medication incidents are documented and reviewed by both management and nursing staff. Disciplinary action as outlined on the attached policy will occur.	

XV. PHARMACY SERVICES

Policy & Rationale: It is the policy of CommuniCare, Inc. to provide pharmacy services through a licensed pharmacy service. Innovative Care Pharmacy is the contract provider of pharmacy services for CommuniCare, Inc. Federal regulations require pharmacy services be provided to persons living in ICF-MR level of care.

Procedures:

1. Pharmacy Review: Pharmacy reviews shall be scheduled by each CCI home's nurse every 90 days and shall be conducted at the home by a pharmacist with the home's nurse. The written doctor's orders shall be compared with the pharmacist's drug profile for each individual receiving medications to determine the accuracy of the drug profile. Refer to Section XIX, "Scheduling of Periodic Appointments and Reviews".

2. Hours of Service: Prescriptions called/faxed to Innovative Care Pharmacy by/before 12:00 pm (noon) will be delivered by courier that same evening. Prescriptions called in after 12:00 pm (noon) will be delivered by courier the next day.

Innovative Care Pharmacy
9196 W. Emerald St., Suite 110
Boise, ID 83704

Phone: (208) 323-1259
Office FAX: (208) 323-8934
Retail Pharmacy Fax: (208) 323-9673
Long-Term Care/Assisted Living Fax: (208) 323-5666

Pharmacy Hours: Monday - Friday
9:00 a.m. – 12:00 pm (noon)
1:00 pm – 5:00 pm

Pharmacist On-Call:
Twenty-four hours a day, seven days a week

E-mail: info@innovativecarepharmacy.com

3. Delivery of Drugs: Innovative Care Pharmacy provides courier delivery to all nine CCI operated homes. Monthly supplies of drugs are placed in crates, secured with a closure, and either sent by courier to CCI homes five (5) business days prior to the end of the month or picked up at the pharmacy by a home's nurse. (If nurses pick up drugs from the pharmacy they must deliver them to the home that same day; drugs are not to remain in the possession of the nurse overnight). If monthly supplies of drugs are needed prior to this time, nurses can contact the pharmacy to make necessary arrangements.

4. Proper Storage of Drugs:
   a) Medications: Each CCI location has a medication cabinet/cart where drugs are locked and stored except during medication pass. The assigned certified Med Passer is responsible for the key to this area.
   b) Narcotics: All Class IV and Class V narcotics must be stored under DOUBLE lock and key except during a medication pass. In other words, they are to be in a locked box in a locked cabinet/cart.
   c) Monthly Supply Crates Delivered from the Pharmacy: All crates from Innovative Care Pharmacy delivered by a courier must be immediately stored in a locked cupboard/cabinet until checked in by a nurse and the assigned Med Passer on duty.
   d) Monthly Supply Crates Picked Up by a Nurse: All crates from Innovative Care Pharmacy picked up by a CCI nurse must remain in a locked vehicle until delivered to the home and checked in by a nurse and the assigned Med Passer on duty.
   e) Replacement/Refill Drugs: If the drug delivered by courier is a replacement or refill, the Med Passer may check it in and then lock it up with the rest of the medications. If a certified Med Passer is not on duty, the crate the replacement/refill is delivered in is to be placed in the designated locked cupboard/cabinet until a certified Med Passer comes on duty.

5. Drug Inventory Control: All drugs must be accounted for when removed from the crate prepared by the pharmacy. The nurse must count the drugs with a Med Passer in the home and both must sign the appropriate records. The nurse must monitor the Drug Inventory/Key Control Record to assure drugs are being accounted for according to procedures outlined in the Medication Administration Module.

6. New Orders/Replacement Drugs: Orders for new and/or replacement drugs must be called/faxed to the pharmacy by a nurse.

7. Physician's Orders: A copy of the physician orders for medications is to be routinely sent to the pharmacy by each home's nurse.

VIII. MEDICAL RECORDS

Policy: A separate medical record/chart documenting the health status and care given to persons who live in CCI operated homes shall be maintained for each such individual.

Rationale: Medical records represent legal communication for documenting health status. In addition, individuals who live in homes that provide ICF-MR levels of care are not typically able to communicate their complete health history and/or current treatment status.

Procedure:

1. Confidentiality: All information in the medical record shall remain confidential.

2. Request for Release of Information: Requests for information from an individual's medical record must be accompanied by an "Authorization to Release Information" form. Information is not to be released without a properly completed form.

3. Request for information from another provider may require a "Request for Information" form depending on the policy of the other provider.

4. Medical Records must be returned to the individual's home as soon as possible after use. Medical records or any part of them (including Medical Observation Logs) are not to be kept out of the home overnight.

5. The medical record is to accompany an individual to all medical appointments.

6. Nursing staff is to assure that physicians and all other providers of care provide documentation regarding individual's appointments and telephone orders. All such information is to be filed in the individual's medical record. The documentation should be obtained at the time of the visit/contact. If this is not possible, the nurse must follow-up with the care provider to secure the information.

7. All documentation in the medical record shall be according to the Guidelines for Medical Documentation contained in Introduction to Health Care module.

8. A summary of all physicians' visits must be documented on the medical observation log by the nurse. If the individual was not accompanied by the nurse, the staff person who accompanied the individual should document a summary of the visit.

9. Medical terminology abbreviations and symbols are not to be used in the medical observation log or on other documents for use by non-medical personnel.

10. Nurses are to document all procedures and nursing assessments performed on an individual in that person's medical observation log.

11. The nurse must do progress charting on all medical/nursing problems. Entries should reflect the on-going status and final resolutions of the problems.

12. Documentation by staff shall be monitored by the nurse and inservice training provided as appropriate.

13. The RN Supervisor will review all CCI Nursing Summaries, Physician's notes, recommendation, orders, and other entries in both the Medical Chart and the medical observation log of each individual on a routine basis, typically monthly, to ensure follow-up by nursing staff. After this review, the RN Supervisor will discuss findings with the LPN assigned to that CCI location and a plan for completion will be developed. Assessment of such plans will be included in the next RN review.

X. MEDICATION INCIDENT DISCIPLINARY ACTION

Policy: It is the policy of CommuniCare, Inc. to protect the health and safety of the individuals who live in its homes by assuring that staff are competent to pass medications according to established practice and procedure and that medication pass double checks are performed by staff to prevent medication errors. Delegation of these activities to unlicensed assistive personnel within CommuniCare, Inc. is under the license of the RN Supervisor.

Prior to passing medications, an employee must have successfully completed the "Assistance with Oral Medications and Assistance with Extended Medications Modules" which includes attendance at an 8 hour class, passing written tests and clinical checklist and an on-site observation by a CCI nurse. As a part of the on-going inservice training, employees will be periodically observed by the location's Assistant QMRP, Instructional Leadworker, and/or nurse. At these times, feedback will be given to the employee about compliance with practices and procedures and supplemental training will occur as necessary. All observation sheets must be routed to LPN and filed at that location RN for review. Nursing and/or management level staff have the authority to suspend an employee who has made a medication error, who has failed to complete a double check, or who is observed violating policies and procedures from passing medication until an investigation has been completed. Any suspension MUST BE discussed immediately with the RN Supervisor and reinstatement can ONLY occur with RN Supervisor approval.

Rationale: Individuals who live in homes which provide ICF-MR levels of care are not typically able to identify the need for and the correct administration of oral medications without supervision. It is imperative that CCI staff is trained to provide instruction to individuals on self-administration procedures while assuring safety procedures.

Procedure

1. Staff are to complete a Medication Incident Report that is kept on file by the home's QMRP when any of the following incidents/errors occurs:
   - Wrong medication taken*
   - Medication taken by the wrong person*
   - Wrong amount of medication taken*
   - Medication taken at the wrong time**
   - Medication taken by a wrong route
   - Medication not taken
   - Medication taken but not documented
   - Dropped medication
   - Wrong # of medication punched out
   - Incorrect key pass procedure
   - If a medication cabinet or cart was left unlocked (a FULL COUNT must be done as soon as possible)
   - Controlled drugs are missing and cannot be accounted for*
   - Other (such as Drug Control procedure not followed, missing blisterpak, etc.)
2. Nursing staff (the home's nurse during normal working hours and the on-call nurse at other times) are to be notified immediately of all medication errors/incidents.
3. The nurse who is contacted will give instructions related to responding to the incident/error. These instructions will be documented on the Medication Incident Report.
4. The completed "Medication Incident Report" will be routed to the home's nurse who will discuss the incident/error with staff involved to determine cause of incident/error and will review procedural requirements to prevent similar incidents in the future. The nurse will also document corrective action taken on the incident report and information on the individual's status in the Medical Observation Log.
5. An asterisk (*) denotes examples of serious medication errors and these are to be reported to the RN Supervisor by nursing staff so that a decision can be made about possible suspension of the staff involved. In addition, if medication pass policy is observed to be violated, any other authorized management level staff can suspend the employee from further medication passes for reasons of safety.
6. If an employee is suspended, the following procedure from CCI's Personnel Manual is in effect:

> "Suspension from Passing Medication may be implemented by an authorized management level staff based in a report of an incident regarding medications. The RN supervisor is to be notified of the suspension on the next working day, will have a conference with the employee and their immediate supervisor as soon as can be arranged, and will make a determination as to whether the suspension from passing medications will continue. If this suspension continues this will automatically trigger a Disciplinary Performance Evaluation" to be completed by the employee's immediate supervisor, which

will outline expectations as specified by the RN Supervisor related to the suspension from passing medications which may include a disciplinary suspension from work without pay for up to five (5) days The employee's status will be reassessed by the RN Supervisor when the stipulations of the suspension from passing medications are resolved and she is the only management level staff that can re-authorize an employee to participate in medication administration procedures. Failure to fulfill the expectations as listed on the Disciplinary Performance Evaluation and/or repeated suspension(s) will result either in termination from employment or demotion to "on-call" status as authorized by the Administrator.

If an employee is/has been suspended from Passing Medication based on a positive drug or alcohol test or a prior drug/alcohol conviction, the decision to allow that employee to again pass medications will be made by the RN Supervisor since this is a delegated duty under the RN license. Each situation will be evaluated individually using the following guidelines:

1) The employee will have a good working history with CCI (attendance, satisfactory performance evaluation, etc.)
2) If Probation/Parole is involved, the employee must have satisfactorily met the conditions of their probation/parole and their Probation/Parole officer must be consulted related to the employee's suitability for having this assignment delegated to him/her.
3) The employee must agree to regular, random drug/alcohol testing according to CCI's Drug Free Work Place Policy.
4) The employee must describe and agree to continue with a good support system (i.e., AA/NA meetings, counseling, continued training, etc).
5) The employee will sign a "Medication Administration Agreement" statement related to the delegation of this responsibility which will be maintained in his/her personnel file.
6) The employee will initially be allowed to pass meds under supervision for a period of time specified by the RN Supervisor.
7) The employee will be required to perform full counts with management staff for a period of time specified by the RN Supervisor.

Any subsequent positive drug/alcohol test will result in immediate termination of employment with CCI unless otherwise authorized by the Administrator.

Bureau of Facility Standards

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MM269	16.03.11.100.04 Insect and Rodent Control Insect and Rodent Control. The facility must be maintained free from insects, rodents and other pests. Chemicals (pesticides) used in the control program must be selected, used, and stored in the following manner: This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to maintain areas to ensure they were free from insects for 9 of 9 individuals (Individuals #1- #9). The findings include: During an environmental observation on 9/16/08 from 8:15 - 9:00 a.m. and 10:00 - 10:30 a.m., it was noted there were no screens on the bedroom windows for the following individuals: - The window of the bedroom shared by Individual #2 and Individual #5 did not have a screen. - The window of the bedroom shared by Individual #1 and Individual #7 did not have a screen. - The window in Individual #4's bedroom did not have a screen. - The window in Individual #6's bedroom did not have a screen. - The window in Individual #9's bedroom did not have a screen. During an interview on 9/17/09 from 10:25 - 10:50 a.m., the QMRP stated window screens were difficult to maintain in the facility. The facility failed to ensure bedroom windows were maintained to keep out insects.	MM269	MM269 These windows are not used for ventilation during the winter months when the they remain closed therefore the screens will be reinstalled near the 1st of April when the windows are likely to be opened for ventilation purposes RECEIVED OCT - 8 2009 FACILITY STANDARDS	10-6-2009

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10-6-09

Bureau of Facility Standards

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MM380	Continued From page 1	MM380	MM380	11-17-2009
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 9 of 9 individuals (Individuals #1 - #9) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: On 9/16/09, an environmental survey was conducted on the east side of the facility from 8:15 - 9:00 a.m., and on the west side of the facility from 10:00 - 10:30 a.m. During those times, the following concerns were noted: a. On the west side of the facility: - There was a hole in the wall behind the bedroom door of Individual #2 and #5. - There was an electrical outlet behind Individual #5's dresser that was missing a face plate. - There was a 1 inch by 1 inch hole in the wall behind the upper left corner of Individual #5's dresser. - There was an anti-tip bracket on Individual #5's dresser that was pulled out from the wall.	MM380	MM380 All nine of the young people living at this home have significant maladaptive behavioral challenges and engage in repeated and frequent episodes of property destruction. An important element of our plan of correction is helping each person gain better management of their behaviors through careful development of programs based on the TEECH model, frequently monitored & updated behavioral support plans, sound psychiatric and medical/nursing care. We are seeing significant progress in this area. We are aware of the need for ongoing repairs and maintenance and have involved our treasure valley maintenance man and the administrator this past summer to assist our contacted maintenance man in the Magic Valley. In fact several of the items mentioned were under repair. We anticipate that this home will normally to be found to have items undergoing or needing repair. We have been replacing the damaged sheet rock (often holes went clear through walls into other rooms) with OSB board and covering that with FRP board in the lower ½ of walls and repairing wholes higher with OSB plastered and textured and painted to look like sheet rock. To date this year (as of 9-30-09) we have spent $34,427 on repairs and equipment at this home and that level of commitment will continue. We were preparing the walls for paint prior to survey and have arranged with a painting contractor to paint the interiors of both sides of the duplex.	

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	13G059	A. BUILDING _____ B. WING _____	09/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNICARE, INC #9 MAIN	876 EAST MAIN JEROME, ID 83338

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MM380	Continued From page 2 - There was a mirror with a crack approximately 3 inches long in the upper left corner in the bathroom by Individuals #2 and #5's bedroom. - There were three holes, approximately 3 inches by 3 inches, in the right set of double doors in the garage and one hole, approximately 3 inches by 3 inches, in the lower part of the left set of double doors. - There was a knob missing from the top drawer of Individual #7's dresser. - There was a crack in the face plate of the electrical outlet between the couch and the patio door. - There was a hole in the siding under the patio light approximately 1 inch by 2 inches. - There was a section of baseboard approximately 2 feet long missing on the right side of Individual #4's closet. - The trim on the corner of the house by the gate had a crack and a hole approximately 10 inches long. - The trim on the corner of the house by the patio had a hole approximately 1 inch by three inches. - The trim on the end of the kitchen counter was missing. - The handle to the refrigerator door was broken. - The refrigerator had three broken door shelf rails, and the deli drawer was broken from its rails.	MM380	We will adjust our present system to more specifically focus the monthly visits by the Administrator on the completion of all repairs identified during this survey in the next 60 days and then continue to use our monthly Preventative check list and personal inspections to prioritize and complete needed repairs.	

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MM380	Continued From page 3	MM380		

- There was a 4 inch section of cabinet wood broken away from the cabinet structure to the right of the dishwasher.

- The baseboard to the left of the tub was missing, and a 2.5 foot section of finish was missing from the wall.

- The caulking at the base of the tub was cracked and missing in sections.

- There was a 1 inch by 1/2 inch hole cut into the flooring in the middle of the tub bathroom.

- The top drawer of the vanity in the tub bathroom was missing.

b. On the east side of the facility:

- The patio light fixture was missing it's cover.

- The exterior light by the front door and by the front walkway were both missing their covers.

- The living room carpet had multiple large stains in front of the couch and in the center of the room.

- There were multiple black marks across the back door along the bottom, and across the middle sections.

- The linoleum along the wall at the back of the dinning area was lifted and peeling from the sub-floor along a 4 foot section.

- There were 3 one-inch sections of plaster missing to the left of the refrigerator.

- There was an 18 inch by 24 inch patched

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MM380	Continued From page 4	MM380		

section of wall to the left of the phone jack that was missing paint.

- There were 4 door shelf rails missing from the refrigerator.

- The deli drawer was broken from its rails in the refrigerator.

- The trim was missing from the edge of the kitchen counter.

- There was a 2 inch by 3 inch hole in the laundry room door.

There was a 1 inch hole in the chemical storage cabinet door.

- There was a large hole through the dry wall exposing studs, partially covered by the dryer, in the laundry room.

- The base boards were missing in individual #9's bedroom, exposing screw heads and the gap between the linoleum and the wall.

- There was a 2 inch, two 4 inch, and a 1 inch section of plaster and paint missing from Individual #9's window sill.

- There was a 1 inch by 1.5 inch section of missing plaster to the left of Individual #9's bedroom door, exposing the particle board beneath.

- There were three drawer pulls missing from Individual #6's dresser.

- Individual #6's bed was missing a 12 inch section of wood from the frame above the right

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MM380	Continued From page 5 drawer, and the drawer was broken from the rails. - There was a 1.5 foot by 3 foot section of patched wall above Individual #6's bed that was missing paint. - The baseboards were missing in Individual #6's closet exposing unfinished drywall. - There was a 3 foot by 2 foot section of patched wall in Individual #6's closet that was missing paint. - There was a 2 inch by 1 inch hole in the wall behind Individual #6's bedroom door. - The shower-head was missing in the bathroom with the tub, and the plaster at the top of the shower enclosure was missing over a 4 inch by 24 inch section. - The wood at the base of the vanity was soft, appeared to be rotting, and had a 1 inch by 2 inch hole near the floor in the bathroom with the tub. - The toilet handle was broken off in the bathroom with the tub. - There was a three inch rip in the linoleum in front of the toilet in the bathroom with the tub. - The left faucet turned in both directions in the bathroom with the tub. - There was a 1.5 foot by 1 foot section of linoleum missing from around the floor vent by the front door. - There was a 1/3 inch gap around the side of the front door, a 1/2 gap under the front door, and the	MM380		

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MM380	Continued From page 6	MM380		

door did not shut tightly. There was light exposure and air coming through the gaps.

- There was a 5 foot section of linoleum pulled up and peeling from the sub-floor along the wall in the entry way.

- The light in the entry way was missing the cover.

- The light in the bedroom shared by Individual #3 and Individual #8 was missing the cover.

- The baseboard was missing behind the bedroom door, in the bedroom shared by Individual #3 and Individual #8, exposing the gap between the linoleum and the wall.

- The door knob was loose on the door to the bedroom shared by Individual #3 and Individual #8.

- Individual #8's dresser was cracked down the left side, and the top two drawers were broken from their rails.

- The hallway light outside Individual #3's bedroom was missing the cover.

- There was a 2 foot by 3 foot section of wall under the sink in the bathroom with the shower that was unfinished wood.

- The right faucet in the bathroom with the shower turned in both directions.

- There was a 1 foot section of calcium build up along the grout in the center of the shower.

The facility failed to ensure environmental repairs

Bureau of Facility Standards

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MM380	Continued From page 7 were maintained.	MM380		
MM696	16.03.11.250.09(d)(i) Refrigerator and Freezer Each refrigerator and freezer must be equipped with a reliable, easily read thermometer. Refrigerators must be maintained at forty-five (45) degrees Fahrenheit or below. Freezers must be maintained at zero degrees - ten (0-10) degrees Fahrenheit or below. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure each freezer was maintained at 0 to 10 degrees Fahrenheit, and each refrigerator and freezer was equipped with a reliable, easily read thermometer for 9 of 9 individuals (Individuals #1 - #9) residing in the facility. This resulted in food being stored under unsafe conditions. The findings include: 1. An environmental review was conducted on the west side of the facility on 9/16/09 from 10:00 - 10:30 a.m. During that time the following concerns were noted: a. The freezer of the refrigerator/freezer combination in the kitchen was noted to be 22 degrees Fahrenheit. The temperature was rechecked with another thermometer and found to be 29 degrees Fahrenheit. The AQMRP, who was present during the review, was notified and stated the food would be discarded and the refrigerator/freezer replaced. The facility failed to ensure freezers were maintained at 0 - 10 degrees Fahrenheit. b. The refrigerator of the refrigerator/freezer combination in the kitchen was noted to have no	MM696	MM696 The refridgerator/freezer on the west side (876 E Main) was replaced during survey process. It is our policy to have thermometers in the cooling and freezing compartments of all units at all times. In this instance it appears that one of the thermometers was moved from the in house refridgerator into the outside freezer as two thermometers were found. Presently all units have thermometers and are operating properly. It is our practice and policy to check to see each unit has a thermometer and is operating properly regularly and recorded by the AQ and or cook. That report is shared on a monthly basis with the RN and Administrator.	10-6-2009

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MM696	Continued From page 8 thermometer. The AQMRP, who was present during the review, was notified and placed a thermometer in the refrigerator. The temperature of multiple food items was checked and found to be at 45 degrees Fahrenheit or below. The facility failed to ensure all refrigerators were equipped with thermometers.	MM696		
MM753	16.03.11.270.02(f)(i) Locked Area All medications in the facility must be kept in a locked area(s) except during those times when the resident is receiving the medication. This Rule is not met as evidenced by: Refer to W382.	MM753	MM753 Please refer to W382	
MM754	16.03.11.270.02(f)(ii) Policies and Procedures The facility must have policies and procedures controlling the administration of residents' medications. Such policies and procedures must be strictly followed by facility personnel. This Rule is not met as evidenced by: Refer to W368.	MM754	MM754 Please refer to W368	